AMENDED IN SENATE JULY 16, 2003

AMENDED IN ASSEMBLY JUNE 2, 2003

AMENDED IN ASSEMBLY APRIL 28, 2003

CALIFORNIA LEGISLATURE—2003–04 REGULAR SESSION

ASSEMBLY BILL No. 1629

Introduced by Assembly Member Frommer

February 21, 2003

An act to amend Sections 128735, 128740, and 128745 of the Health and Safety Code, relating to statewide health planning and development.

LEGISLATIVE COUNSEL'S DIGEST

AB 1629, as amended, Frommer. Office of Statewide Health Planning and Development: health facility data.

The Health Data and Advisory Council Consolidation Act requires the Office of Statewide Health Planning and Development to collect specified health facility data from every organization that operates, conducts, owns, or maintains a health facility. Existing law requires the office's data reporting requirements in this regard to be consistent with national standards, as applicable.

This bill would additionally require every organization that operates, conducts, or maintains a health facility licensed as a general acute care hospital, an acute psychiatric hospital, or a special hospital to provide to the office the health facility data information required under existing law for all affiliates, as defined by the bill, as well as other entities over which the organization exercises control, responsibility, or governance commencing July 1, 2004. The bill would specify the required reporting

elements for the health facility or affiliate, and for a corporate entity that exercises control, responsibility, or governance over a material portion of the assets or operations of the health facility or affiliate. The bill would also require the office to review the reporting requirements specified in the bill, commencing July 1, 2004.

The bill would also specify the standards that the office is required to consider in developing its data reporting requirements.

Under the existing Health Data and Advisory Council Consolidation Act, each hospital is required to report to the office specified financial and utilization data. Existing law also requires the office to adopt guidelines for the identification, assessment, and reporting of hospital charity care services.

This bill would specify the information the office is required to consider in establishing these guidelines.

This bill would also require the office to consult with the State Department of Health Services regarding how the data collected facilitates the enforcement of statutes and regulations regarding staffing in specified health facilities.

The Health Data and Advisory Council Consolidation Act also requires the office to publish risk-adjusted outcome reports for specified surgeries.

This bill would~~, commencing July 1, 2006,~~ also ~~require~~ *authorize* the office to publish risk-adjusted outcome reports for coronary angioplasty surgeries.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 128735 of the Health and Safety Code is amended to read:

128735. Every organization that operates, conducts, owns, or maintains a health facility, and the officers thereof, shall make and file with the office, at the times as the office shall require, all of the following reports on forms specified by the office that shall be in accord where applicable with the systems of accounting and uniform reporting required by this part, except the reports required pursuant to subdivision (g) shall be limited to hospitals:

(a) A balance sheet detailing the assets, liabilities, and net worth of the health facility at the end of its fiscal year.

(b) A statement of income, expenses, and operating surplus or deficit for the annual fiscal period, and a statement of ancillary utilization and patient census.

(c) A statement detailing patient revenue by payer, including, but not limited to, Medicare, Medi-Cal, and other payers, and revenue center except that hospitals authorized to report as a group pursuant to subdivision (d) of Section 128760 are not required to report revenue by revenue center.

(d) A statement of cashflows, including, but not limited to, ongoing and new capital expenditures and depreciation.

(e) A statement reporting the information required in subdivisions (a), (b), (c), and (d) for each separately licensed health facility operated, conducted, maintained by, or affiliated with, the reporting organization, except those hospitals authorized to report as a group pursuant to subdivision (d) of Section 128760.

(f) Data reporting requirements established by the office shall be consistent with national standards, as applicable. Standards that shall be considered in developing the data reporting requirements include those developed by consumer organizations, organizations of purchasers of health care coverage, and recognized collective bargaining organizations.

(g) A Hospital Discharge Abstract Data Record that includes all of the following:

(1) Date of birth.

(2) Sex.

(3) Race.

(4) ZIP Code.

(5) Principal language spoken.

(6) Patient social security number, if it is contained in the patient's medical record.

(7) Prehospital care and resuscitation, if any, including all of the following:

(A) ''Do not resuscitate'' (DNR) order at admission.

(B) ''Do not resuscitate'' (DNR) order after admission.

(8) Admission date.

(9) Source of admission.

(10) Type of admission.

(11) Discharge date.

(12) Principal diagnosis and whether the condition was present at admission.

(13) Other diagnoses and whether the conditions were present at admission.

(14) External cause of injury.

(15) Principal procedure and date.

(16) Other procedures and dates.

(17) Total charges.

(18) Disposition of patient.

(19) Expected source of payment.

(20) Elements added pursuant to Section 128738.

(h) It is the expressed intent of the Legislature that the patient's rights of confidentiality shall not be violated in any manner. Patient social security numbers and any other data elements that the office believes could be used to determine the identity of an individual patient shall be exempt from the disclosure requirements of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(i) No person reporting data pursuant to this section shall be liable for damages in any action based on the use or misuse of patient-identifiable data that has been mailed or otherwise transmitted to the office pursuant to the requirements of subdivision (g).

(j) A hospital shall use coding from the International Classification of Diseases in reporting diagnoses and procedures.

(k) (1) Every organization that operates, conducts, or maintains a health facility licensed pursuant to subdivision (a), (b), or (f) of Section 1250, shall provide information as specified in this section on all affiliates or other entities, if any, in California over which the organization exercises control, responsibility, or governance of a material amount of the assets or operations of the entity. For purposes of this section, ''affiliate'' has the same meaning as in Section 5031 of the Corporations Code.

(2) (A) A health facility that provides information, as required by this section, shall identify the corporate entity, if any, that exercises control, responsibility, or governance over a material portion of the assets or operations of that health facility.

(B) A corporate entity, wherever domiciled, that is identified by a health facility pursuant to subparagraph (A), shall provide information on all affiliates or other entities, if any, in California, over which that corporate entity exercises control, responsibility,

or governance over a material portion of the assets or operations of that affiliate or entity.

(C) In providing information on any affiliate or other entity, the health facility or corporate entity, as applicable, shall also identify any other health facility or corporate entity that exercises control, responsibility, or governance over a material portion of the assets or operations of the identified affiliate or entity.

(3) Reporting elements for the corporate entity shall include, but shall not be limited to, all of the following:

(A) The financial information specified by subdivisions (a), (b), (c), and (d), for the entire corporation.

(B) The financial information specified by subdivisions (a), (b), (c), and (d), for those operations located in California.

(C) ~~A~~ *For those affiliates required to provide home office cost reports for Medicare and medicaid, a* disclosure of home office cost reports.

(4) The reporting elements for affiliates that provide patient care shall include both financial information pursuant to subdivisions (a), (b), (c), and (d), and patient utilization data consistent with ~~Sections 128736 and 128737~~ *Section 1216. The patient confidentiality provisions of subdivision (h) shall apply to the reporting of information pursuant to this subdivision.*

(5) The reporting elements for affiliates that do not provide patient care shall include financial information pursuant to subdivisions (a), (b), (c), and (d). *For purposes of this paragraph, affiliates that do not provide patient care shall also include pharmacy, laboratory, and radiology services.*

(6) Notwithstanding paragraph (1), the term ‘‘affiliate’’ does not include a health care service plan licensed pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2, a risk-bearing organization, as described in subdivision (g) of Section 1375.4, that contracts with a health service plan, or a licensed health insurer that provides insurance as described in paragraphs (1) to (8), inclusive, of subdivision (b) of Section 106 of the Insurance Code.

(7) For affiliates that are otherwise required to report pursuant to this chapter, this section shall not be construed to require preparation of duplicate reports.

(8) The office shall periodically review the reporting elements specified in this subdivision to determine whether its regulations,

procedures, or protocols assure that the reporting elements provide timely information that meets the needs of purchasers, consumers, and regulators of health services. In so doing, the office shall consult with associations of licensed health facilities, consumer organizations, labor organizations, physician membership organizations, the State Department of Health Services, the Department of Managed Health Care, and other interested parties.

(9) This subdivision shall become operative on July 1, 2004.

SEC. 2. Section 128740 of the Health and Safety Code is amended to read:

128740. (a) Commencing with the first calendar quarter of 1992, the following summary financial and utilization data shall be reported to the office by each hospital within 45 days of the end of every calendar quarter. Adjusted reports reflecting changes as a result of audited financial statements may be filed within four months of the close of the hospital's fiscal or calendar year. The quarterly summary financial and utilization data shall conform to the uniform description of accounts as contained in the Accounting and Reporting Manual for California Hospitals and shall include all of the following:

(1) Number of licensed beds.

(2) Average number of available beds.

(3) Average number of staffed beds.

(4) Number of discharges.

(5) Number of inpatient days.

(6) Number of outpatient visits.

(7) Total operating expenses.

(8) Total inpatient gross revenues by payer, including Medicare, Medi-Cal, county indigent programs, other third parties, and other payers.

(9) Total outpatient gross revenues by payer, including Medicare, Medi-Cal, county indigent programs, other third parties, and other payers.

(10) Deductions from revenue in total and by component, including the following: Medicare contractual adjustments, Medi-Cal contractual adjustments, and county indigent program contractual adjustments, other contractual adjustments, bad debts, charity care, restricted donations and subsidies for indigents, support for clinical teaching, teaching allowances, and other deductions.

(11) Total capital expenditures.

(12) Total net fixed assets.

(13) Total number of inpatient days, outpatient visits, and discharges by payer, including Medicare, Medi-Cal, county indigent programs, other third parties, self-pay, charity, and other payers.

(14) Total net patient revenues by payer including Medicare, Medi-Cal, county indigent programs, other third parties, and other payers.

(15) Other operating revenue.

(16) Nonoperating revenue net of nonoperating expenses.

(b) Hospitals reporting pursuant to subdivision (d) of Section 128760 may provide the items in paragraphs (7), (8), (9), (10), (14), (15), and (16) of subdivision (a) on a group basis, as described in subdivision (d) of Section 128760.

(c) The office shall make available at cost, to any person, a hard copy of any hospital report made pursuant to this section and in addition to hard copies, shall make available at cost, a computer tape of all reports made pursuant to this section within 105 days of the end of every calendar quarter.

(d) The office, with the advice of the commission, shall adopt by regulation guidelines for the identification, assessment, and reporting of charity care services. In establishing the guidelines, the office shall consider the principles, guidelines, and other information provided by consumer organizations, recognized collective bargaining agents of health care workers, recognized collective bargaining agents of workers whose employers purchase health care coverage, and organizations representing purchasers of health care coverage. In addition, the office shall also consider the principles and practices recommended by professional health care industry accounting associations for differentiating between charity services and bad debts. The office shall further conduct the onsite validations of health facility accounting and reporting procedures and records as are necessary to assure that reported data are consistent with regulatory guidelines.

(e) To further its mission as the single state agency for collecting health data, the office shall also consult with the State Department of Health Services regarding how the data collected facilitates enforcement of statutes and regulations regarding

staffing in a general acute care hospital, as defined in subdivision (a) of, an acute psychiatric hospital, as defined in subdivision (b) of, and a special hospital, as defined in subdivision (f) of, Section 1250, and regarding staffing in a skilled nursing facility, as defined in subdivision (c) of Section 1250. In determining whether to revise data collected on staffing, the office shall consult with recognized collective bargaining agents for health care workers, consumer organizations with demonstrated interest on the issue of staffing, and associations of the facilities in question.

SEC. 3. Section 128745 of the Health and Safety Code is amended to read:

128745. (a) Commencing July 1993, and annually thereafter, the office shall publish risk-adjusted outcome reports in accordance with the following schedule:

Publication Date	Period Covered	Procedures and Conditions Covered
July 1993	1988–90	3
July 1994	1989–91	6
July 1995	1990–92	9

Reports for subsequent years shall include conditions and procedures and cover periods as appropriate.

(b) The procedures and conditions required to be reported under this chapter shall be divided among medical, surgical and obstetric conditions or procedures and shall be selected by the office, based on the recommendations of the commission and the advice of the technical advisory committee set forth in subdivision (j) of Section 128725. The office shall publish the risk-adjusted outcome reports for surgical procedures by individual hospital and individual surgeon unless the office in consultation with the technical advisory committee and medical specialists in the relevant area of practice determines that it is not appropriate to report by individual surgeon. The office, in consultation with the technical advisory committee and medical specialists in the relevant area of practice, may decide to report nonsurgical procedures and conditions by individual physician when it is appropriate. The selections shall be in accordance with all of the following criteria:

(1) The patient discharge abstract contains sufficient data to undertake a valid risk adjustment. The risk adjustment report shall ensure that public hospitals and other hospitals serving primarily low-income patients are not unfairly discriminated against.

(2) The relative importance of the procedure and condition in terms of the cost of cases and the number of cases and the seriousness of the health consequences of the procedure or condition.

(3) Ability to measure outcome and the likelihood that care influences outcome.

(4) Reliability of the diagnostic and procedure data.

(c) (1) In addition to any other established and pending reports, on or before July 1, 2002, the office shall publish a risk-adjusted outcome report for coronary artery bypass graft surgery by hospital for all hospitals opting to participate in the report. This report shall be updated on or before July 1, 2003.

(2) In addition to any other established and pending reports, commencing July 1, 2004, and every year thereafter, the office shall publish risk-adjusted outcome reports for coronary artery bypass graft surgery for all coronary artery bypass graft surgeries performed in the state. In each year, the reports shall compare risk-adjusted outcomes by hospital, and in every other year, by hospital and cardiac surgeon. Upon the recommendation of the technical advisory committee based on statistical and technical considerations, information on individual hospitals and surgeons may be excluded from the reports.

(3) Unless otherwise recommended by the clinical panel established by Section 128748, the office shall collect the same data used for the most recent risk-adjusted model developed for the California Coronary Artery Bypass Graft Mortality Reporting Program. Upon recommendation of the clinical panel, the office may add any clinical data elements included in the Society of Thoracic Surgeons' database. Prior to any additions from the Society of Thoracic Surgeons' database, the following factors shall be considered:

(A) Utilization of sampling to the maximum extent possible.

(B) Exchange of data elements as opposed to addition of data elements.

(4) Upon recommendation of the clinical panel, the office may add, delete or revise clinical data elements, but shall add no more

than a net of six elements not included in the Society of Thoracic Surgeons' database, to the data set over any five-year period. Prior to any additions or deletions, all of the following factors shall be considered:

(A) Utilization of sampling to the maximum extent possible.

(B) Feasibility of collecting data elements.

(C) Costs and benefits of collection and submission of data.

(D) Exchange of data elements as opposed to addition of data elements.

(5) The office shall collect the minimum data necessary for purposes of testing or validating a risk-adjusted model for the coronary artery bypass graft report.

(d) In addition to any other established and pending reports, ~~commencing July 1, 2006, and every year thereafter, the office shall~~ *the office may* publish risk-adjusted outcome reports for coronary angioplasty surgery for all coronary angioplasty surgeries performed in the ~~state. In each year, the reports shall compare risk-adjusted outcomes by hospital, and in every other year, by hospital and surgeon. Upon the recommendation of the technical advisory committee based on statistical and technical considerations, information on individual hospitals and surgeons may be excluded from the reports.~~ *state if the office determines, with the consensus of the commission and technical advisory committee, that the outcome reports are feasible and would be of value to health care consumers, purchasers, and providers. In making this determination, the office, based on the recommendations of the technical advisory committee, shall consider whether to exclude information on individual hospitals and surgeons from the reports.*

(e) The annual reports shall compare the risk-adjusted outcomes experienced by all patients treated for the selected conditions and procedures in each California hospital during the period covered by each report, to the outcomes expected. Outcomes shall be reported in the five following groupings for each hospital:

(1) ''Much higher than average outcomes,'' for hospitals with risk-adjusted outcomes much higher than the norm.

(2) ''Higher than average outcomes,'' for hospitals with risk-adjusted outcomes higher than the norm.

(3) ''Average outcomes,'' for hospitals with average risk-adjusted outcomes.

(4) ''Lower than average outcomes,'' for hospitals with risk-adjusted outcomes lower than the norm.

(5) ''Much lower than average outcomes,'' for hospitals with risk-adjusted outcomes much lower than the norm.

(f) For coronary artery bypass graft surgery reports and any other outcome reports for which auditing is appropriate, the office shall conduct periodic auditing of data at hospitals.

(g) The office shall publish in the annual reports required under this section the risk-adjusted mortality rate for each hospital and for those reports that include physician reporting, for each physician.

(h) The office shall either include in the annual reports required under this section, or make separately available at cost to any person requesting it, risk-adjusted outcomes data assessing the statistical significance of hospital or physician data at each of the following three levels: 99 percent confidence level (0.01 p-value), 95 percent confidence level (0.05 p-value), and 90 percent confidence level (.10 p-value). The office shall include any other analysis or comparisons of the data in the annual reports required under this section that the office deems appropriate to further the purposes of this chapter.

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